837 Institutional Claims Frequently Asked Questions

Q. Where can I find the rules for required and conditional data elements?

A. For this information you should read and follow the rules presented in the HIPAA-mandated 837 version 4010 Implementation Guide and addenda.

Q. Where can I find information related to Medicaid-specific identifiers?

A. To access this information you should read and follow the rules in the Medicaid 837 companion document.

Q. Where can I locate information on testing claims with Michigan Medicaid?

A. Information on 837 claims testing with Michigan Medicaid can be found in the Medicaid B2B Testing document. This document can be accessed using the following link: http://www.michigan.gov/documents/B2B_Testing_Instructions_MV_Feb_10_03_pdflinks_57409_7.pdf , or by going to www.michigan.gov/mdch, Providers, HIPAA, HIPAA Implementation Materials.

Q. My claims keep getting hung up because of an "Invalid Sender ID", can you tell me what the problem might be?

A. There are two potential areas that could be affected:

i. Submitters must use the four-character submitter ID provided by MDCH. The ID number (also known as the "Billing Agent ID Number" or the "Service Bureau ID") is a four-digit alpha or numeric code, in the format 00XX, where the first two digits are zeroes and the last two digits are unique alpha and/or numeric values assigned by MDCH to each specific submitter. (Example: 0011, 001A, 00AA, etc.) The submitter ID is used to identify all electronic files submitted to MDCH and must be included in all submissions.

ii. Loop 1000A NM09 must equal the value reported in segment GS02, the Application Sender's Code.

Q. What does it mean to have an "Invalid HL01"?

A. HL01, Hierarchical ID Numbers, must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.

Q. Do I need prior authorization?

A. Missing or invalid prior authorization will result in pended claims.

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Q. What is an "Invalid Billing/Pay-to Provider ID"?

A. The Billing Provider Name (2010AA) and Billing Provider Secondary Identification Number (REF02) must be a valid 9-digit value in order for claims to be compliant.
   i. Use the 9-digit provider identifier assigned by MDCH (2-digit provider type, followed by a 7-digit assigned ID).
   ii. No spaces or hyphens.
   iii. ID should pass check digit routine.

Q. What should be included in the Subscriber Primary Identifier (Loop 2010BA, NM109) to avoid submitting an "Invalid Subscriber ID"?

A. The Subscriber Primary Identifier should be the patient's 8-digit beneficiary ID number assigned by MDCH.

Q. I am having some difficulty with Coordination of Benefits information, any advise?

A. Coordination of Benefits information must be provided in Loops 2320 and 2330. Here are a few tips to help you avoid running into difficulty with your COB transaction:
   i. "Incorrect Payer Responsibility Sequence Number" - SBR01, Loops 2000B and 2320 should contain:
      a. A single "P" (primary) payer;
      b. A single "S" (secondary) payer (if applicable);
      c. Only multiples of "T" (tertiary) payers are allowed on a claim, and must be proceeded by a single "P" payer and "S" payer;
      d. MDCH coverage information should be reported in Loop 2000B only. Loop 2320 is reserved for reporting coverage under other payers.
   ii. "Invalid Payer Identification Codes" – Loop 2330B-NM109 must report:
      a. Position 1: Alpha-numeric character "Source of Payment";
      b. Positions 2-6: "Payer Identification";
      c. Positions 7-10: As outlined in the Michigan Uniform Billing Manual (Also see the MDCH website for carrier codes at: www.michigan.gov/mdch);
         i. Example values used for this field (BCBSM = "G00210", Medicare Part A (United Government Services) = "C00452", and Medicare Part B (Wisconsin Physician Services) = "C00953".
   iii. Information required if other payers are known to be potentially involved in paying of the claim:
      a. When other payers are adjudicated at the claim level:
         i. Other payer adjudication information should be provided at the service line level (Loop 2320).
      b. When other payers are adjudicated at the service line level:
         i. Other payer adjudication information should be provided at the service line level (Loop 2430).
      c. Other payer adjudication information should balance at the service line, claim, and transaction level as specified in the 835 Implementation Guide.

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Q. What information do I need to add if I have generated an "Invalid or Missing Attending Provider ID" response?

A. Attending Physician Name (Loop 2310A) and Attending Physician Secondary Identification Number (REF02) must combine to become a valid 9-digit value. You should use the 9-digit provider identifier assigned by MDCH (2-digit provider type, followed by the 7-digit MDCH assigned ID). If a provider is not enrolled with Medicaid, use a series of nine "8"s (Example: 888888888). Do not submit spaces or hyphens. The ID should pass the check digit routine.

Q. What if I have more than two occurrence span codes to go with a single claim?

A. The third occurrence span code should be reported as an occurrence code using the qualifier "BH".

Q. What does it mean to have a "Missing or Invalid Original CRN" on a claim replacement or void/cancelled claims?

A. Claim frequency type codes (third position of "Type of Bill") "7" and "8" require a valid 10-digit MDCH assigned CRN for the last approved claim be reported in Loop 2300 REF02-Claim Original Reference Number.
